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	495409	A. BUILDING _____ B. WING _____	C 03/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 3/21-22/16. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 3 current Resident review (Resident #2,#3, #4) and 1 closed record review (Resident #1).	F 000		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, closed clinical record review and in the course of a Complaint	F 314	F314	4/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/13/2017

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F 314	Continued From page 1 investigation, it was determined that the facility staff failed to provide physician ordered pressure ulcer treatments for 1 of 4 Residents in the sample survey, Resident #1. The Findings Included: On March 9, 2017 the State Agency received a Complaint that alleged that the facility staff failed to prevent pressure sores on a Resident, who will be identified as Resident #1. The allegation also alleged that the facility staff did not provide interventions to treat and prevent the development of pressure ulcers. Resident #1 was an 89 year old male who was admitted on 8/11/16 and discharged to a hospital on 3/3/17. Admitting diagnoses included, but were not limited to: right femur fracture, dysphagia, chronic respiratory failure, urinary tract infection, hypertension, atrial flutter, heart failure, major depression, cataracts, osteoarthritis, congestive heart failure and failure to thrive. The most current Minimum Data Set (MDS) assessment located in the closed clinical record was a Quarterly MDS assessment with an Assessment Reference Data (ARD) of 2/5/17. The facility staff coded that Resident #1 had a Cognitive Summary Score of 2. The facility staff also coded that Resident #1 required extensive assistance (3/3) with Activities of daily Living (ADL's). In Section M. Skin Conditions the facility staff coded that Resident #1 had 2 Stage 2 pressure ulcers. The facility staff additionally coded in Section M. 1200 that Resident #1 received a pressure reducing device for chair, a pressure reducing device for the bed and received pressure ulcer care.	F 314	1.It is duly noted Resident#1□s closed record lacked documentation of physician ordered treatments. Resident #1 no longer resides at the facility. 2.Any resident with pressure ulcers is at risk for lacking treatment documentation. An audit of any resident with pressure ulcer treatment orders as of 3/21/17 will be conducted for February and March 2017 as appropriate. 3.DON or designee will educate licensed staff on documentation to include pressure ulcer treatment. 4.DON or designee will audit patients with pressure ulcer treatments daily (M-F) x4 weeks,then weekly x8 weeks to ensure treatment(s) are documented per physician order. Any variance will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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F 314	Continued From page 2 On March 21, 2017 at 2:30 p.m. the surveyor reviewed Resident #1's closed clinical record. Review of the closed clinical record produce physician order sheets that were signed and dated by the physician on 3/9/17. Signed physician orders included, but were not limited to: "Cleanse pressure injury to right heel with wound cleanser, pat dry with 4X4, apply skin prep to peri wound, apply wound gel to wound bed, cover with foam dressing. Change daily and prn (as needed) every daily and prn. (order originated on 1/5/17). Cleanse pressure injury on right buttocks with wound cleanser, pat dry with 4X4, apply wound gel, cover with foam dressing. Change every Tue (Tuesday), fri (Friday) and pm (every evening) every day shift Tue, Fri for pressure injury area. (order originated on 1/24/17). Cleanse sheered area to left ischium with wound cleanser, pat dry with 4X4 and cover with foam dressing for protection. In the morning every Tue, Fri for sheered skin to ischium. (order originated on 2/17/17). Cover Right Ischium with padded foam dressing for the prevention of skin breakdown. In the morning every 2 day(s) for prevention of skin breakdown due to pressure. (order originated on 2/22/17). Skin prep to bilateral heels q (every) day topical. (order originated on 9/10/16). Skin prep to left heel topical every day shift (order originated on 1/5/17 and d/c'ed (discontinued) on 2/22/17). Skin prep to left heel once a day topical. Every night shift for DTI (deep tissue injury). (order originated on 1/16/17). Float heels while in bed at all times for prevention. (order originated on 10/7/16). Zinc Oxide Ointment 10% Apply to buttocks topically two times a day for skin condition for 10 days Apply zinc oxide to buttocks BID (twice a day) cover with dressing pad xs (times) 10 Days. (order originated on 2/24/17)." (sic)	F 314		

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F 314	Continued From page 3	F 314		

Continued review of the closed clinical record produced the February and March 2017 Treatment Administration Records (TAR's). Review of the February and March 2017 TAR's failed to document the following:

Pressure ulcer care to the right heel with skin prep, pat dry with 4X4, apply wound perl to wound bed and cover with foam dressing was not done on 2/10/17, 2/12/17, 2/25/17 and 2/26/17.

Pressure ulcer care to the right buttocks with wound cleanser, pat dry with 4X4 and apply wound gel and cover with a foam dressing was not done on 2/10/17.

Covering the right ischium with the padded foam dressing was not done on 2/26/17 and 3/2/17.

Skin prep to bilateral heels was not done on 2/10/17, 2/12/17, 2/15/17, 2/25/17 and 2/26/17.

Skin prep to the left heel was not done on 2/10/17 day shift, 2/12/17 day shift.

Zinc oxide to buttocks twice a day was not done on 2/25/17, 2/26/17, and 3/2/17 at 9 a.m.

Floating the heels at all times was not done on 2/10/17 day shift, 2/12/17 day shift, 2/15/17 day shift and 2/16/17 day shift.

Further review of the closed clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following care plans for pressure ulcers/care. "Focus: Resident has alteration skin & potential risk for further skin break down D/T (due to) commodities, and

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F 314	Continued From page 4	F 314		

immobility. Wounds not likely to heal due to poor PO (by mouth) intake, non-compliant with turning, and functional decline. Interventions/Tasks: Pad, Protect or position body with support devices to protect bony prominence. Wound care as ordered. Document progress, update MD on changes as needed." (sic)

On March 21, 2017 at 4 p.m. the surveyor notified the Acting Director of Nursing (ADON) of the Complaint. The surveyor informed the ADON that Resident #1 had multiple pressure areas and that physician ordered treatments/interventions were not provided by the staff as ordered. The surveyor reviewed the closed clinical record with the ADON. The surveyor reviewed the signed physician orders and the February and March 2017 TAR's. The surveyor notified the ADON that the facility staff had not documented that wound care was provided as ordered by the physician on multiple occasions.

On March 22, 2017 at 12:15 p.m. the survey team met with the Administrative Team (AT) which consisted of the Administrator (Adm), ADON, Regional Compliance Nurse (RCN), Corporate MDS Nurse, QAPI Nurse, Assistant Administrator (AAdm) and a Medical Records staff person. The surveyor notified the AT that a Complaint had been received in the State Agency and that the complaint alleged that Resident #1 did not get physician ordered pressure ulcer care and interventions. The surveyor notified the AT that Review of the February and March 2017 TAR's had not documented pressure ulcer care or interventions as ordered by the physician. The surveyor notified the AT that the Complaint would be Substantiated with an associated deficient Practice.

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F 314	Continued From page 5 No additional information was provided prior to exiting the facility as to why the facility staff failed to provide physician ordered pressure ulcer treatments and interventions to Resident #1. This is a Complaint Deficiency.	F 314		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 315		4/14/17

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F 315	Continued From page 6 continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and closed clinical record review, it was determined that the facility staff failed to obtain physician orders for an Indwelling Foley catheter for 1 of 4 Residents in the sample survey. The Findings Included: Resident #1 was an 89 year old male who was admitted on 8/11/16 and discharged to a hospital on 3/3/17. Admitting diagnoses included, but were not limited to: right femur fracture, dysphagia, chronic respiratory failure, urinary tract infection, hypertension, atrial flutter, heart failure, major depression, cataracts, osteoarthritis, congestive heart failure and failure to thrive. The most current Minimum Data Set (MDS) assessment located in the closed clinical record was a Quarterly MDS assessment with an Assessment Reference Data (ARD) of 2/5/17. The facility staff coded that Resident #1 had a Cognitive Summary Score of 2. The facility staff also coded that Resident #1 required extensive assistance (3/3) with Activities of daily Living (ADL's). In Section H. Bladder and Bowel the facility staff coded that Resident #1 had an indwelling catheter.	F 315	F315 1.It is duly noted Resident #1□s closed record lacked a current order for indwelling catheter. Resident #1 no longer resides at the facility. 2.Any resident with an indwelling catheter is at risk for lacking a physician order for the catheter. An audit of residents with Foley indwelling catheters will be conducted to observe for physician order to include catheter size, bulb size and routine care and services. Any variances will be corrected as identified. 3.DON or designee will educate licensed staff on assessment and documentation of Indwelling Catheters including physician order for catheter size, bulb size and routine care and services. 4.DON or designee will audit newly admitted patients with an indwelling catheter or any resident in-house who receives an order for an indwelling catheter daily (M-F) x4 weeks, then weekly x8 weeks to ensure there is an	

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F 315	Continued From page 7 On March 21, 2017 at 2:30 p.m. the surveyor reviewed Resident #1's closed clinical record. Review of the closed clinical record produce physician order sheets that were signed and dated by the physician on 3/9/17. Signed physician orders included did not include an order for Foley catheter care to include catheter size, bulb size, routine care and services. Continued review of the closed clinical record produced the outputs from the Foley catheter from 2/21/17 through 3/3/17. Further review of the closed clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following care plans for the indwelling Foley catheter. "Focus: Resident has a Indwelling Catheter: BPH. He has had confusion and pulls at it at times. Interventions/Tasks: CATHETER size per MD order, Change catheter per MD order and/or facility procedure, Check tubing for kinks and reposition as needed, Intake and output as ordered or indicated, Nursing may irrigate foley per order, Observe and report pain/discomfort due to catheter for further assessment, Observe and report to MD s/sx (signs and symptoms) UTI (urinary tract infection): pain, burning blood tinged urine, cloudiness, no output, deepening or urine color, increased pulse, increased temp (temperature), Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observe for s/sx of discomfort on urination and frequency. Report if present. Position catheter tubing to minimize risk of pressure to skin and skin breakdown." (sic)	F 315	order for indwelling catheter that includes catheter size, bulb size and routine care and services. Any variances will be addressed and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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F 315	Continued From page 8	F 315		

On March 21, 2017 at 4 p.m. the surveyor notified the Acting Director of Nursing (ADON) that the Quarterly MDS with the ARD of 2/5/17 indicated that Resident #1 had an indwelling Foley catheter. The surveyor asked the ADON if Resident #1 had a Foley catheter throughout his stay at the facility. The ADON stated, "Yes." The surveyor notified the ADON that review of Resident #1's closed clinical record did not produce physician orders for an indwelling Foley catheter to include catheter size, bulb size and routine care and treatment. The surveyor reviewed the closed clinical record with the ADON. The surveyor pointed out that current signed physician orders did not include orders for a Foley catheter. The surveyor notified the ADON that the orders for the Foley catheter had been discontinued in December 2016.

On March 22, 2017 at 12:15 p.m. the survey team met with the Administrative Team (AT) which consisted of the Administrator (Adm), ADON, Regional Compliance Nurse (RCN), Corporate MDS Nurse, QAPI Nurse, Assistant Administrator (AAdm) and a Medical Records staff person. The surveyor notified the AT that Resident #1 had an indwelling Foley catheter for the duration of his stay at the facility. The surveyor notified the AT that review of the closed clinical record did not produce a current physician order for Foley catheter size, bulb size and routine care and services. The surveyor notified the AT that the order for the Foley catheter had been discontinued in December 2016.

No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain physician orders for an indwelling Foley catheter to include catheter size, bulb size and

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F 315	Continued From page 9 routine care and services for Resident #1.	F 315		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's	F 328		4/14/17

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F 328	Continued From page 10 goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on staff interview, closed clinical record review and in the course of a Complaint investigation, it was determined that the facility staff failed to provide oxygen as ordered by the physician for 1 of 4 Residents in the sample survey, Resident #1. The Findings Included: On March 9, 2017 the State Agency received a Complaint that alleged that the facility staff failed to provide oxygen as ordered to a Resident, who will be identified as Resident #1. The Complainant alleged that on 2/24/17 Resident #1 was in bed and the oxygen was disconnected at the oxygen concentrator. The Complainant alleged that the Resident #1's was not receiving oxygen.	F 328	F328 1.It is duly noted that Resident#1 closed clinical records indicate the oxygen humidifier tube was disconnected from the oxygen concentrator on 2/14/17 as reported by visitors to C.N.A. and was reconnected upon such report by the licensed nurse. It is duly noted Resident # 1□s closed medical record indicates the medication administration record (MAR) for February and March 2017 lack documentation of administration of oxygen Resident #1 no longer resides at the facility. 2.Any resident with routine oxygen administration is at risk if oxygen is not	

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F 328	Continued From page 11 Resident #1 was an 89 year old male who was admitted on 8/11/16 and discharged to a hospital on 3/3/17. Admitting diagnoses included, but were not limited to: right femur fracture, dysphagia, chronic respiratory failure, urinary tract infection, hypertension, atrial flutter, heart failure, major depression, cataracts, osteoarthritis, congestive heart failure and failure to thrive. The most current Minimum Data Set (MDS) assessment located in the closed clinical record was a Quarterly MDS assessment with an Assessment Reference Data (ARD) of 2/5/17. The facility staff coded that Resident #1 had a Cognitive Summary Score of 2. The facility staff also coded that Resident #1 required extensive assistance (3/3) with Activities of daily Living (ADL's). In Section M. Skin Conditions the facility staff coded that Resident #1 had 2 Stage 2 pressure ulcers. The facility staff additionally coded in Section O. Special Treatments, Procedures, and Programs that Resident #1 received oxygen. On March 21, 2017 at 2:30 p.m. the surveyor reviewed Resident #1's closed clinical record. Review of the closed clinical record produce physician order sheets that were signed and dated by the physician on 3/9/17. Signed physician orders included, but were not limited to: "O2 (oxygen) at 3 L/m (liters per minute) via nasal cannual continuously every shift for COPD (chronic obstructive pulmonary disease)." (sic) Further review of the closed clinical record produced nursing "Progress Notes." The nursing progress notes documented on 2/14/17 at 12:15	F 328	properly connected and if documentation of oxygen administration is lacking. An audit of residents with current orders for routine oxygen administration will be conducted to see if oxygen is properly connected and if others are at risk for missing documentation. Any variances will be corrected as identified. 3.DON or designee will educate licensed staff on documentation of routine oxygen administration on the MAR as well as checking concentrators for functioning when in rooms for medication pass or rounds. C.N.A.s will be educated to notice and report any problem with O2 delivery system. 4.DON or designee will audit patients with routine oxygen administration daily (M-F) x4 weeks, then weekly x8 weeks to ensure proper O2 administration and documentation per physician order. Any variances will be addressed and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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p.m. the following: "CNA (certified nursing assistant) came to this nurse and stated that pt (patient) had 2 female visitors, these visitors requested to speak with nurse. This nurse went to pt room and the 2 female visitors stated that pt was lying in bed with the Oxygen off., upon assessing nurse noted that the humidifier was loose form the O2 concentrator and pt was not receiving oxygen, humidifier was reconnected and O2 began flowing. O2 then in use via NC (nasal cannula) ... (sic)

Continued review of the closed clinical record produced the February and March 2017 Medication Administration Records (MAR's). Review of the February and March 2017 MAR's failed to document the following:
Oxygen not documented as administered on 2/1/17, 2/12/17, 2/15/17, 2/16/17, 2/24/17, 2/25/17 and on 3/1/17 on day shift.

Further review of the closed clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following care plans for pressure ulcers/care. "Focus: (Name of Resident withheld) is at risk for altered respiratory status due to COPD. Interventions/Tasks: Give oxygen as ordered by the physician. ..."(sic)

On March 21, 2017 at 4 p.m. the surveyor notified the Acting Director of Nursing (ADON) of the Complaint. The surveyor informed the ADON that Resident #1 had a physician order to administer oxygen at 3 liters per minute via a nasal cannula continuously. The surveyor notified the ADON that review of the February and March 2017 MAR's failed to document the administration of the oxygen on multiple occasions. The surveyor reviewed the closed clinical record with the

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F 328	Continued From page 13 ADON. The surveyor pointed out the specific physician order for the oxygen to be given at 3 l/m continuously. The surveyor then reviewed the February and March 2017 MAR's. The surveyor pointed out that the facility staff had not documented that the oxygen was administered on multiple days. On March 22, 2017 at 12:15 p.m. the survey team met with the Administrative Team (AT) which consisted of the Administrator (Adm), ADON, Regional Compliance Nurse (RCN), Corporate MDS Nurse, QAPI Nurse, Assistant Administrator (AAdm) and a Medical Records staff person. The surveyor notified the AT that a Complaint had been received in the State Agency and that the complaint alleged that Resident #1 did not get his oxygen as ordered by the physician. The surveyor notified the AT that review of the February and March 2017 MAR's failed to document the physician ordered oxygen as being administered. The surveyor notified the AT that the Complaint would be Substantiated with an associated deficient Practice. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide oxygen as ordered by the physician to Resident #1. This is a Complaint Deficiency.	F 328		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		4/14/17

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F 329	Continued From page 14 drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and closed clinical record review, it was determined that the facility staff failed to ensure that 2 of 4 Residents in the	F 329	F329 1.It is duly noted that Resident #1 and #4	

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F 329	Continued From page 15 sample survey were free of unnecessary medications, Resident #1 and Resident #4. The Findings Included: 1. For Resident #1 the facility staff failed to monitor for antidepressant drug use, Remeron and Trazodone, to include specific behaviors, interventions. side effects and effectiveness. Resident #1 was an 89 year old male who was admitted on 8/11/16 and discharged to a hospital on 3/3/17. Admitting diagnoses included, but were not limited to: right femur fracture, dysphagia, chronic respiratory failure, urinary tract infection, hypertension, atrial flutter, heart failure, major depression, cataracts, osteoarthritis, congestive heart failure and failure to thrive. The most current Minimum Data Set (MDS) assessment located in the closed clinical record was a Quarterly MDS assessment with an Assessment Reference Data (ARD) of 2/5/17. The facility staff coded that Resident #1 had a Cognitive Summary Score of 2. The facility staff also coded that Resident #1 required extensive assistance (3/3) with Activities of daily Living (ADL's). In Section N. Medications the facility staff coded that Resident #1 received 7 days of an antidepressant. On March 21, 2017 at 2:30 p.m. the surveyor reviewed Resident #1's closed clinical record. Review of the closed clinical record produce physician order sheets that were signed and dated by the physician on 3/9/17. Signed physician orders included, but were not limited to: "Remeron Tablet 30 Mg (Mirtazapine) Give 30 mg	F 329	lack documentation of psychotropic drug monitoring to include specific behaviors, interventions and side effects. Resident #1 no longer resides at the facility. Resident #4□s record has been reviewed and revised to include needed monitoring. 2.Any resident with psychotropic drugs ordered is at risk for lacking appropriate monitoring and documentation. An audit of residents with psychotropic medication orders will be conducted to see if others are at risk for missing psychotropic monitoring. Records will be corrected as identified. 3.DON or designee will educate licensed staff on psychotropic drug monitoring and documentation. 4.DON or designee will audit 10 residents on psychotropic medication, including any resident with newly ordered psychotropic medication, weekly x4 weeks, then bi-weekly x8 weeks to ensure monitoring for psychotropic medication is initiated and being completed per protocol. Any variance will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.	

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by mouth at bedtime for Depression and agitation related to MAJOR DEPRESSIVE DISORDER, UNSPECIFIED. TraZODone HCl Tablet 50 MG Give 1 tablet by mouth for insomnia." (sic)

Further review of the closed clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus" and "Interventions/Tasks." "Focus: (Name of resident withheld) is at risk for adverse effects of psychotropic medications due to depression, anxiety and dementia with disturbances. HX (history) of hallucinations. Interventions/Tasks: Administer medications as ordered; observe for side effects and effectiveness of medications. See MAR. Observe target behaviors for decrease or escalation that may indicate need for medication review. Utilize non-pharmacological interventions whenever possible to address symptoms/behaviors. See behavior plan, See activities plan." (sic)

Continued review of the closed clinical record produced the February and March 2017 Medication Administration Records (MAR's). Review of the February and March 2017 MAR's documented that Resident #1 was receiving the physician order Remeron and Trazodone.

Further review of the closed clinical record failed to produce monitoring for the use of the antidepressants, Remeron and Trazodone, to include specific behaviors, interventions, side effects and effectiveness.

On March 22, 2017 at 8:05 a.m. the surveyor notified the Regional Compliance Nurse (RCN). The surveyor informed the RCN that Resident #1 had physician orders to administer Remeron and

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Trazodone, antidepressants. The surveyor notified the RCN that review of the February and March 2017 MAR's documented that the facility staff were administering the medications as ordered by the physician. The surveyor notified the RCN that review of the closed clinical record failed to produce monitoring for the use of the Remeron and Trazodone. The surveyor reviewed the closed clinical record with the RCN. The surveyor pointed out the specific physician orders for the Remeron and Trazodone. The surveyor then reviewed the February and March 2017 MAR's. The surveyor pointed out that the facility staff had administered the medications as ordered by the physician, however, no monitoring of specific behaviors, interventions, side effects and effectiveness could be located.

On March 22, 2017 at 12:15 p.m. the survey team met with the Administrative Team (AT) which consisted of the Administrator (Adm), Acting Director of Nursing (ADON), RCN, Corporate MDS Nurse, QAPI Nurse, Assistant Administrator (AAdm) and a Medical Records staff person. The surveyor notified the AT that Resident #1 was receiving Antidepressants, Trazodone and Remeron, and that medication monitoring for specific behaviors, interventions, side effect or effectiveness could not be located in the clinical record.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #1 was free from unnecessary medications. The facility staff had not done medication monitoring for Remeron and Trazadone.

2. For Resident #4, the facility staff failed to assess and monitored for behaviors ensuring she

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was free from an unnecessary medication.

The clinical record of Resident #4 was reviewed on 3/21/17 through 3/22/17. Resident #4 was admitted to the facility on 11/16/16 with diagnoses that included but were not limited to: anxiety, diabetes, stroke, high blood pressure, dementia, schizophrenia and Parkinson disease.

Resident #4's most recent MDS (minimum data set) assessment, completed on this resident was a quarterly assessment with an ARD (assessment reference date) of 03/09/17. Section C (cognitive patterns) of this assessment coded the resident as 8 out of 15. In section B, the resident was coded to understand and to be understood.
Review of Resident #4's physicians summary of orders revealed the order for Abilify tablet 2 mg give 1 tablet by mouth in the morning related to paranoid schizophrenia. She also was taking Aricept 10 mg 1 tablet by mouth at bed time for dementia.

Review of the March 2017, medication administration record (MAR) revealed she was given the Abilify tablet 2 mg give 1 tablet by mouth in the morning, and the Aricept 10 mg 1 tablet by mouth at bed time. The MAR did not reveal any corresponding behavior monitoring sheets to indicate behavior monitoring was being done.
There was no documentation in the January, February, or March 2017, progress notes that identified assessment of or the targeted behavior that Resident #6 exhibited prior to the administration of either of the medications.
On 3/22/17 at 11:45 am, the interim director of nurses was asked if Resident #4 should have

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F 329	Continued From page 19 behavior monitoring sheets. She replied, "Yes". On 3/22/17 at approximately 12:00 noon, the administration staff was informed of the failure to monitor and document behaviors and or the non-pharmacological interventions prior to the starting of the medications and continuing administration of the medications. No further information was provided to the surveyor prior to exit on 3/20/2017.	F 329		